Texas Department of Insurance
Division of Workers' Comp
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

DALLAS COUNTY HOSPITAL
P O BOX 660599
DALLAS TX 75266-0599

Carrier's Austin Representative Box
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MFDR Date Received
DECEMBER 5, 2011

Respondent Name
ACE AMERICAN INSURANCE CO

MFDR Tracking Number
M4-12-1030-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary Taken From the Table of Disputed Services: "Did not pay per drg"

Amount in Dispute: $15,393.64

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "After reviewing the bill in question for dates of service 07/18/2011-08/08/2011, it has been determined that bill has already been allowed at the correct reimbursement. Our repricer has confirmed that the bill was processed under IPPS values and calculations as published by CMS Medicare for provider Medicare # 450015 with the 143% Texas specific mark-up."

Response Submitted by: Ace Group/ESIS WC, P O. Box 6563, Scranton, PA 18505

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 18, 2011 Through August 8, 2011	Inpatient Hospital Surgical Services	$15,393.64	$15,393.64

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Texas Administrative Code §134.404 sets out the guidelines for reimbursement of hospital facility fees for inpatient services.
3. 28 Texas Administrative Code §134.404(e) states that: "Except as provided in subsection (h) of this section, regardless of billed amount, reimbursement shall be:

(1) the amount for the service that is included in a specific fee schedule set in a contract that complies with the requirements of Labor Code §413.011; or

(2) if no contracted fee schedule exists that complies with Labor Code §413.011, the maximum allowable reimbursement (MAR) amount under subsection (f) of this section, including any applicable outlier payment amounts and reimbursement for implantables."

(3) If no contracted fee schedule exists that complies with Labor Code §413.011, and an amount cannot be determined by application of the formula to calculate the MAR as outlined in subsection (f) of this section, reimbursement shall be determined in accordance with §134.1 of this title (relating to Medical Reimbursement).

4. 28 Texas Administrative Code §134.404(f) states that "The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors as published annually in the Federal Register. The following minimal modifications shall be applied.

   (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:
   (A) 143 percent; unless
   (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 108 percent."

5. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated September 9, 2011
   - 1– W1– Worker's Compensation State Fee Schedule Adjustment.
   - 1– The charge for this procedure exceeds the fee schedule allowance. (Z710)
   - 2– This bill was reviewed for ESIS treatment parameters. (MT39)
   - *– This charge was reviewed through the Clinical Validation Program. (Z355)

   Explanation of benefits dated November 17, 2011
   - 1– W1– Worker's Compensation State Fee Schedule Adjustment.
   - 1– The charge for this procedure exceeds the fee schedule allowance. (Z710)
   - 2– This bill was reviewed for ESIS treatment parameters. (MT39)
   - *– We are unable to recommend an additional allowance since this claim was paid in accordance with the state's fee schedule guidelines, First Health Bill Review's usual and customary policies, and/or was reviewed in accordance with the provider's contract with First Health. (Z951)
   - *– This charge was reviewed through the Clinical Validation Program. (Z355)

Issues

1. Were the disputed services subject to a specific fee schedule set in a contract between the parties that complies with the requirements of Labor Code §413.011?
2. Can the maximum allowable reimbursement (MAR) amount for the disputed services be determined according to 28 Texas Administrative Code §134.404(f)?
3. Did the facility or a surgical implant provider request separate reimbursement for implantables in accordance with 28 Texas Administrative Code §134.404(g)?
4. Is the requestor entitled to additional reimbursement for the disputed services?

Findings

1. The insurance carrier reduced or denied disputed services with reason "We are unable to recommend an additional allowance since this claim was paid in accordance with the state's fee schedule guidelines, First Health Bill Review's usual and customary policies, and/or was reviewed in accordance with the provider's contract with First Health. (Z951)." Review of the submitted information finds insufficient documentation to support that the disputed services are subject to a contractual agreement between the parties to this dispute. The above denial/reduction reason is not supported. The disputed services will therefore be reviewed for payment in accordance with applicable Division rules and fee guidelines.
2. Review of the submitted documentation finds that the maximum allowable reimbursement (MAR) amount for the disputed services can be determined according to 28 Texas Administrative Code §134.404(f).
3. Review of the submitted documentation finds no request for separate reimbursement of implantables in accordance with 28 Texas Administrative Code §134.404(g). Consequently, reimbursement will be calculated in accordance with division rule at 28 Texas Administrative Code §134.404(f)(1)(A).

4. 28 Texas Administrative Code §134.404(e) states that: "Except as provided in subsection (h) of this section, regardless of billed amount, reimbursement shall be (1) the amount for the service that is included in a specific fee schedule set in a contract that complies with the requirements of Labor Code §413.011." Reimbursement for the disputed services is calculated in accordance with 28 Texas Administrative Code §134.404(f)(1)(A) as follows: The Medicare facility-specific reimbursement amount including outlier payment amount for DRG 928 is $53,362.91. This amount multiplied by 143% is $76,308.96. The total maximum allowable reimbursement (MAR) is therefore $76,308.96. The respondent previously paid $60,915.32, therefore an additional amount of $15,393.64 is recommended for payment.

Conclusion

For the reasons stated above, the division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $15,393.64.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $15,393.64 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	September 6, 2012 Date
Signature	Medical Fee Dispute Resolution Manager	September 6, 2012 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.